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ABSTRACT

The author focuses on a number of key issues which appear to be common to a variety of alcohol treatment programs which have as their intention the amelioration of alcohol problems. The aim in this paper is to call attention to these issues and to discuss their implications for the manner in which health care workers think about alcohol problems, their effect on staff relationships, and the manner in which the staff decides to provide services. In short, the author suggests that the solutions to problems are not independent of how they are perceived, and one may learn more about alcohol problems by not focusing on them per se, but on how care workers think about them. Issues under examination include: (1) organizational self-preservation; (2) the physical setting and environment as a significant impact on an organizations' processing of its clientele; (3) the displacement of goals by an organization; (4) the biases of health care providers; (5) social stratification variables as they affect one's perception of problems; and (6) the effect of suggestion, label, variability, and labeler on the deviance-defining process. (Author/PC)

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CHALLENGES AND ISSUES IN PRIVATE PRACTICE IN WORKING WITH ADDICTED PEOPLE

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CHALLENGES AND ISSUES IN PRIVATE PRACTICE IN WORKING WITH ADDICTED PEOPLE

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Alcoholism is clearly one of the major health problems in the United States. The size of the problem is unclear, although a number of estimates provided by varying, but overlapping definitions of the problem suggest about ten percent of the drinking populace are affected.

Alcoholism can be described, but there is no clear cut objectively definable dividing line between the alcoholic and non-alcoholic drinker. Who is doing the defining becomes then the critical variable, in identifying what it is, and therefore what is to be done about what is.

Alcoholism does involve three key issues in its description and definitions. These include: 1) a large quantity of alcohol consumed over a period of years, 2) abnormal chronic loss of control over drinking, e.g. either the inability to refrain or the inability to stop, and 3) causing chronic damage to the person's physical health, social standing or interpersonal relationships. The aspect of causing chronic damage to the person's physical health may no longer apply to the largest category of individuals who satisfy the first two criteria, but they have

become the most visible portion, and usually because of their accessibility to institutional programs (vs outpatient).

There are major changes occurring in the field regarding many aspects of the problems associated with alcoholism, and which include definitions, concepts of etiology, development, and consequently in regard to remedies which we hope to provide.

The traditional notions of loss of control, alcoholism as a disease, denial, craving, motivation and surrender; and abstinence as the principal treatment goal are now under serious challenge. Mere notions have been absorbed by the alcohol field and alcohologists as fact, and as fact they have been institutionalized to a point where they provide the fundamental rationale for the development and implementation of a wide variety of treatment services. This is especially reflected in the variety of modalities and programs developed over time aiming towards abstinence as the principal treatment outcome, e.g. chemical and electrical conditioned reflex aversion, antabuse, programs in state mental hospitals, private mental hospitals, etc.

The one dimensional approach to the understanding and remediation of alcoholism began a semi-official change with the now famous article by Davies in 1962 in which he noted that some alcoholism patients were drinking socially and successfully over a rather extended period of time. This was followed by a series of reports essentially noting the same phenomenon--and which outcomes were not the intentions of any intervention programs.

With the advent of well done panel surveys and behavior modification techniques the evidence is far from complete but is certainly persuasive that the traditional interpretations of the key notions of loss of control, craving, the disease concept, motivation, denial, etc., no longer apply.

A re-definition of the condition is mandatory, and I would propose that the learning perspective, with some increased emphasis on the social aspects (as opposed to the psychological) seems to hold the most promise in understanding it's development, sustaining powers, and consequently its remediation. Addiction to alcohol then can be considered a learned or conditioned response, and this proposition gains more ascendency in view of the increasing evidence which does not support the concept of a physiological addiction.

This is reflected partially in the criteria for the diagnosis of alcoholism recently developed by the National Council on Alcoholism in conjunction with the American Psychiatric Association. In their criteria, for example, the notion of "loss of control" can only be identified by the patient-subject. It cannot be enforced by the examiner, and craving is not listed anywhere.

This brief review brings us to two issues which are persistently present in the caretakers attempts to deliver his services. These issues are 1) the concept of motivation need by the caretakers, and 2) the organizational imperatives which effect the conduct of the caretakers.

MOTIVATION

Concepts of motivation held by the caretaker appear directly related to the responses or answers the healer has developed in order to remediate the problem. Those who possess a limited answer or response tend to have a more narrow view of motivation, i.e. that it is primarily an intrapsychic phenomenon--and that the subject-patient holds all of the trump cards regarding the success of the enterprise. Those caretakers who possess a more broad perspective, and answers for

the subject-patient, tend to have a broader concept of motivation--they recognize that social contingencies in the patient's life, e.g. job, family relationships, timing; options the caretaker possesses in providing treatment or care opportunities, and the qualitative aspects of the interpersonal encounter play powerful roles in treatment sought for, engaged in, and in the outcomes achieved--clearly, motivation is a sometime thing.

As I have viewed our activities as caretakers it becomes more and more apparent that the answer(s) we have proposed becomes the determining criteria regarding concepts of motivation, and we need to caution ourselves against our answers becoming more important than the person.

The subject-patient's selection of you as the helper is a partial explanation for him regarding his condition, and therefore some aspect of the remedy already exists. Our task is to fully explore this selection process as a principal source of information in developing a framework for doing our work.

ORGANIZATIONAL IMPERATIVES

Let me briefly turn to the issue of organizational imperatives. Here our focus will be on a number of key issues which appear to be common to a variety of alcohol

programs which have as their intention the amelioration of alcohol problems. The aim is to call attention to these issues and to discuss their implications on the manner in which alcohologists think about alcohol problems, their affect on staff relationships and in particular the manner in which the staff decides to provide services. In examining these issues it is important to keep in mind the role each issue plays in shaping the thinking about the nature of alcohol problems and the kinds of services such problems, so shaped, require. In short, I suggest that the solutions to problems are not independent of how they are conceived. Consequently, we may learn more about alcohol problems by not focusing on them per se, but on how alcohologists think about them.

1. Organizational self preservation is the first issue to consider. That is to what extent does the organization provide services to meet the needs of its clients or do the structural arrangement and objectives of the organization impell it to shape clients to fit its own needs?

A substantial amount of sociological literature exists which clearly documents how the informal patterns of social control shape the processes which are developed to provide services to individuals (see Kitsuse, 1970; Becker, 1963; Deutscher, 1974;

Bogdan, 1972). In a discussion of evaluational issues, Etzioni was quoted to the effect that about 50% of any agency's activities, no matter what its stated goals, are really involved in its own maintenance and that this is an intervening variable which needs to be taken into account in any evaluation of any agency's program and effectiveness. Illustrative of this point was the situation facing the March of Dimes when they achieved their objective of stamping out polio, there was a post achievement crisis - "How the hell do we survive?"...so they re-defined their objectives (1971).

Taking a hypothetical case, perhaps in a hospital centered treatment program, it would not be uncommon to change the nature and content of services offered to patients depending on the occupancy rate and the need to increase the number of individuals who receive such services. This constraint may change the criteria for admission into the institution; the movement from one portion of a program to another, or in developing new or different variants of different services. It is conceivable, in this example, for the hospital based program to resist the development of an extensive outpatient services because of its direct challenge for keeping the inpatient beds full. If, however, the outpatient service was defined as being available only to those who had received the hospital's extensive

inpatient treatment, there would be no organizational conflict. In much the same way, an outpatient clinic may not define its clients as in need of inpatient services since the clinic does not provide this type of service. This myopic view of defining the needs of the client in terms of the services that can be provided by the organization clearly indicates the power of the organizational imperative to survive. These factors can exert a considerable force on the content of the services provided by an organization despite the common assertion of a need for continuity of care. Unfortunately, continuity of care to some organizations simply means providing only those services which it offers.

2. This displacement of goals by an organization can lead to the development of strained relationships between administration and treatment staff in health care programs and between custodial and treatment staff in custodial insitutions (Zald, 1960). This is a second issue that needs to be examined in terms of its impact on the conceptualization of alcohol problems.

The role relationships internally among staff of an organization are principally affected by the locus of authority and control. In this context then, the stated treatment policy will in large part reflect the thinking of those in power. Staff

who do not fully subscribe to the organization's treatment philosophy may then be subject to a wide spectrum of sanctions depending on the degree to which their divergent viewpoint undermines the thinking of those in control. It is important to underscore the strength of this issue for it is reflected in the fact that what an organization defines as its services is often simply a matter of how it conceives of the problem. The relativity of diagnostic labels has been successfully captured by Cahn who offered the following definition of alcoholism: "Alcoholism is a label attached to a drinking pattern defined as deviant by the social control institutions" (1970: p. 36).

3. <u>The physical setting and environment is a third factor that has a significant impact on an organization's processing of their clientele</u>. Rossi and Filstead (1972) found that controlling for a variety of factors, patients admitted for alcoholism to a closed psychiatric unit in a general hospital were far less likely to enter a rehabilitation program than patients who were initially admitted to an open psychiatric unit. Rosenham (1972) and others (Goffman, 1961; Scheff, 1966; Spradley, 1970) indicated very clearly the impact both the physical environment and the ideologies of the staff have on the judgements professionals make regarding

the problems of their clientele. In Rosenham's study, eight pseudo patients, (same people) gained secret admission to 12 different hospitals. They alleged a common set of symptoms: (i.e., complaining that he had been hearing voices - unclear, but they seemed to say "empty", "hollow", and "thud". The voices were unfamiliar and were of the same sex as the pseudo patient). Beyond alleging the symptoms and falsifying name, vocation, and employment, no further altercations of person's history or circumstances were made, i.e., they then acted as they ordinarily would, and they recounted their histories and relationships as they actually existed. During their stay they experienced marked depersonalization, i.e., had the sense they were invisible and were not "seen" by the staff - or were unworthy of account. The pseudopatients were eventually discharged, but with one or another kind of psychotic diagnosis, "in remission". None were considered normal.

The Rosenham study clearly suggests that we cannot distinguish the same from the insane in psychiatric hospitals and that the hospital imposed a treatment environment in which the meaning of behavior can easily be misunderstood. He aptly concluded that the extent to which we refrain from sending distressed persons to insane places, our impressions of them are less likely to be distorted.

4. A fourth factor to consider is the biases of health care providers. Selectivity based on the biases of health care providers is among the most powerful ingredients effecting the labeling, diagnosing and prognosing of patients. Health care providers have clear preferences for particular therapeutic modalities, and they view their role and competence in ways that emphasize certain problem areas and exclude others. Recently the Braginskys (1974) have asserted that the dominance of the Protestant Ethic is principally accountable for the hypothesis that psychiatric diagnoses made by professionals are little more than translations of sterotypes and prejudgements about other people. They further believe that the labeling process of diagnosing tells us nothing about the recipients, but instead reveals a great deal about the men who use them and the society which they serve. In their opinion diagnostic labels do not reflect salient characteristics of the person who is observed, but rather reflect the ideology and value premises of the observer.

This may seem to be an extreme position, however, the supporting data for this proposition is powerful and pursuasive in pointing out that the client's condition is only one of the number of contingencies affecting the societal,

and consequently agency's response and therefore the fate of the individual (see Kutsuse, 1970; Filstead, 1972; Schur, 1971). In a study by Greenley (1972), he has established that the families desire to bring a patient home was the most powerful determinant of his length of hospitalization. Importantly, Greenley was able to clearly identify this factor irrespective of the patient's psychiatric condition. Norman Denzin (1968) also found that notions held by therapists regarding how the patient is accepting the "psychiatric line" was significantly related to prognosis, hours of personal therapy per week and length of hospitalization. In this study, the data was gathered retrospectively, i.e., the interactions between the therapist were not observed.

These findings suggest that the therapist selectively perceives information about the patient and then acts toward the patient on the basis of this information; communicating his impressions to the patient in the process. The patient in turn, makes inferences about the therapist and about the therapist's view of him. Possessing less than complete knowledge about treatment and his role as patient, the patient tends to confirm the therapist's initial inference and thus the self-fulfilling prophecy has run full circle.

To a large extent we can say that in order for an individual to receive services from an organization, the individual has to conform to the stereotypes and expectations the organization makes of him. In discussing Scott's (1970) work on blindness, Schur makes the following observation:

> Of the agency programs themselves, Scott has declared that personnel tend to hold notions about blindness different from those of newly blind people. They view blindness of 'one of the most severe of all handicaps, the effects of which are long lasting, pervasive, and extremely difficult to ameliorate,' and they insist, subtly or not so subtly, that their clients adopt the same view. How the blind person himself feels about his disability and what he thinks that he can accomplish despite it are often ignored, or at least resisted, by such workers. The client is under great pressure to accept the agency's definition of his problem and may not be permitted to continue in more advanced stages of the agency program unless he shows such "insight" (1971, p. 93).

5. <u>Social stratification variables are a fifth factor that affect one's perception of problems.</u> The relationship between powerlessness and commitment rates clearly

point out the importance social class and cultural issues have as they affect the deviance defining process. The previous works of Hollingshead and Redlich (1958), and most recently that of Linsky (1972) and Rushing (1972) continue to show the strong relationship between psychiatric commitment and social class and other social characteristics. In the alcohol field the work of Blane, et.al. (1963), Chafetz (1970), Schmidt, et.al. (1968) and most recently that of Edwards (1974) provide strong evidence regarding the impact of socio-cultural and social class factors as they relate to the treatment sought, the treatment provided, and the outcome of such intervention for alcohol problems. One is immediately reminded in this context of Cahn's (1970) admonition and recommendation that treatment services for alcoholism patients be instituted on a social class basis with the hoped for intent of a more suitable meeting of needs and services.

The treatment ideology of a given agency can have a most powerful impact on who is selected, defined and hence treated. As Cahn indicated "predictability criteria reinforce professional ideologies of who is treatable" (Cahn, 1970) and this has been further documented in the extensive review by Pattison (1974).

The strong relationship between concepts of motivation and treatment issues

is discussed in some detail in this paper and this relationship has been examined by many clinicians (e.g. Chafetz, 1970; Kaumans, et.al., 1967; Meyer, et. al. 1966) as critical to the treatment enterprise, and studied by others (Sterne and Pittman, 1965; Mogar, 1969; Rossi and Filstead, 1972) to identify some of its critical components.

6. The effect of suggestion, label, variability, and labeler on the deviance defining process attests to the unreliability of a spectrum of psychiatric opinions officially expressed by some alcohologists. This is documented in two studies which directly pertain to our concerns regarding non-patient characteristics or contingencies which affect and in some instances, severely clouds the sought after professional opinions.

Temerlin (1968) studied the influence of suggestion on psychiatric diagnosis. He found that psychologists and psychiatrists are extremely suggestible when it comes to diagnosing mental illness. Four different groups diagnosed the patient in the same recorded interview under different conditions. One control group diagnosed with no prior suggestion, one group was given a suggestion that the interviewee was sane, and a third group was told that they were selecting scientists

to work in reasearch. In the experimental group, it was suggested that the interviewees were mentally ill. The diagnosis of the control and experimental group differed greatly. In the control groups the great majority made diagnoses of mental health, whereas in the experimental group not a single psychiatrist out of twenty-five, and only three out of twenty-five psychologists, diagnosed mental health.

Finally, Mulford's (1967) work in this regard is noteworthy. He indicated that community professionals seldom diagnose alcoholism; they simply validate the judgements of the family, or whoever is the complainant, that the subject is "some kind of an excessive drinker" and that this occurs especially when there are clues that the subject fits the stereotype of the skid-row alcoholic. In conclusion, I think the awareness of not knowing which 'twin was the Toni' should provide some incentive to review our activities in order to meet the needs of our clientele more properly, and with great concern for his individuality.